STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155738	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON HOME	**206 E MARION ST SOUTH BEND, IN 46601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: August 5, 6, 7, and 8, 2013 Facility number: 001141 Provider number: 155738 AIM number: 200905640 Survey Team: Julie Baumgartner, RN TC Shelly Vice, RN Brenda Meredith RN (8/05, 8/06, 2013) Sharon Ewing, RN Census bed type: SNF: 6 SNF/NF: 19 Residential: 24 Total: 49 Census payor type: Medicare: 6 Medicaid: 14 Other: 29 Total: 49 Residential Sample: 7 The Milton Home was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Recertification and State Licensure Survey.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE